Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		IS ENTIN 10, WIGHT WOME ET W	A. BUILDING: _			-125
		N039003	B. WING		08/1	1/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ATTICA LO	ONG TERM CARE FACIL	ITY 302 N BOTI ATTICA, KS				
(X4) ID	SUMMARY ST	AT TICA, RS	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	VE ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE	
S 000	INITIAL COMMENTS		S 000			
	Health Resurvey and	represents the findings of a complaint investigations , 74149, 71216, 70388 and				
S 600 SS=F	28-39-158(a) DIETARY SERVICES		S 600			
90 1	Dietary services. The nursing facility shall provide each resident with nourishing, palatable, attractive, non-contaminated foods that meet the daily nutritional and special dietary needs of each resident. A facility that has a contract with an outside food management company shall be found to be in compliance with this regulation if the company meets the requirements of these regulations.					
	(a) Staffing.					
	dietetic services shall responsibility of a full- licensed dietitian or a who receives regularl supervision from a lic	time employee who is a dietetic services supervisor y scheduled onsite ensed dietitian. The nursing ufficient support staff to				
	policies and procedur dietetic services depart	ty shall implement written es for all functions of the ortment. The policies and vailable for use in the				
		rvices supervisor shall meet stated in K.A.R. 28-39-144(r)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 08/13/2014 FORM APPROVED

Kansas D	Department on Aging					
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		N039003	B. WING		08/11/2014	
NAME OF B		0.70557.41			1	
NAME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
ATTICA LO	ONG TERM CARE FACIL	ITY 302 N BO				
	I	ATTICA, I	KS 67009	т		
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
S 600	Continued From page		S 600			
0 000	Continued From page	<i>3</i> 1	3 000			
	-:					
		Γ is not met as evidenced				
	by:					
	KAR 28-39-158(a)(1)					
		nsus of 51 residents. All 51				
	-	epared in the main kitchen.				
		n, interviews, and record				
		enrollment schedule, the				
	facility failed to assign	etic services to a full time				
		censed dietician or a dietetic				
		Certified Dietary Manger)				
	who receives regularl	• • •				
	supervision from a lic	-				
	Supervision nom a	ensea dictition.				
	Finding included:					
	-Review of the billing	from Dietary Consultant E				
		d the facility for 10 ½ hours				
	the week of July 1st, 19 hours the week of July 7th, 18 hours the week of July 14th, 17 hours the week of July 21st, and 23 hours the week of July					
	28th.					
	5	t fan Diatam				
		ervices account for Dietary				
		ent enrollment receipts dated				
	8/5/14 revealed dietary staff D to be enrolled in Human Resource Management and Field					
		n Resources Management The fall of 2014 dietary staff				
	Food Service, along v	nitation and Management of				
		gement of Food Systems.				
	-	working towards his/her				
	Certified Dietary Man					
ļ	Certified Dietary Mari	ager Certificate.	1			

PRINTED: 08/13/2014 FORM APPROVED

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	N039003	B. WING		08/11/2014	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ATTICA LONG TERM CARE FACILITY	Y ATTICA, K				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
facility 3 of the 4 days. An interview with Dietary 11:15 a.m. revealed staf certified as the Dietary Menrolled in the Certified program, taking classes College, and planned to During an interview on 8 Administrator A reported dietician who was at the and monitored weights, eating difficulties. Dietar meal preparation and mD did not meet the requiservices supervisor. The full time Registered Diet monitoring of staff, while	week of 8/4/14 through Consultant E was in the Try Staff D on 8/4/14 at suff D was not currently Manager. He/she was Dietary Manager at a local Community of finish in spring of 2015. 8/4/14 at 1:12 p.m., do the facility had a certified be facility three days weekly diets, and residents for rry staff D monitored staff, neal service. Dietary staff uirements of a dietetic be facility failed to provide a tician to provide overall be staff D continued to dietary Manager Certificate. Sign overall supervisory of services to a full time censed dietician or a risor who received	S 600			